



Division 12

CLINICAL SCIENCE

Society for the Science of Clinical Psychology
Section III of the Division of Clinical Psychology of
the American Psychological Association

developing clinical psychology as an experimental-behavioral science



Newsletter

Fall 2005 Issue

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INSTRUCTIONS FOR AUTHORS

Clinical Science is published as a service to the members of Section III of the Division of Clinical Psychology of the American Psychological Association. The purpose is to disseminate current information relevant to the goals of our organization.

Feature Articles may be submitted to the editor via e-mail. They should be approximately 16 double-spaced pages and should include an abstract of 75- to 100- words.

Brief Articles may also be submitted, and should also include a 75- to 100-word abstract.

All articles should be submitted as an attachment to an e-mail and formatted according to the *Publication Manual of the American Psychological Association, 5th edition*.

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Articles published in *Clinical Science* represent the views of the authors and not necessarily those of the Society for a Science of Clinical Psychology, the Society of Clinical Psychology, or the American Psychological Association. Submissions representing differing views, comments, and letters to the editor are welcome.

Special Section: Prescription Privileges for Psychologists

Prespectives from two Past Presidents of SSCP

Over the past decade the American Psychological Association (APA) has aggressively campaigned for prescription privileges for psychologists. However, many clinical psychologists, including many SSCP members, strongly oppose expanding our discipline to include prescribing psychiatric medications. Criticisms have ranged from concerns about the impact of prescription privileges on our scientific and professional identity to concerns about public safety associated with proposed training programs. In the following articles, Kenneth Sher and Don Fowles summarize their exchanges with APA about prescription privileges during their SSCP Presidencies.



Kenneth J. Sher, Ph.D.
University of Missouri, Columbia
Email: SherK@missouri.edu

2003 SSCP President

In the interest of full disclosure, I want to state unequivocally at the outset that I am not against the idea, *in principle*, that appropriately trained psychologists should be granted prescriptive authority in jurisdictions that have approved such practice by statute. However, there is a large divide between the ideal of appropriate training and what appears to be the reality of training in 2005, and I have become extremely concerned with what appears to be a systematic erosion of the arguably minimal training standards set out in the APA model curriculum that was passed by APA council in 1996 (and is, thus, the official APA policy).

I also confess that I do not know what an appropriate training would look like. But I definitely have some strong biases about the context of training. For one, I think that admission to training programs should be highly selective and that only those individuals who have a strong background in the life sciences, as well as a doctoral degree in psychology and appropriate pre- and post-doctoral training for treating mental disorders, should be allowed to enroll. I also think that, like our colleagues in psychiatry, training should occur in the context of a full-time program, where trainees are in residence for an extended period of time (e.g., similar to the

expectation of medical schools and psychiatric residency programs) and receive intensive, daily immersion in didactics and supervised practice in a supportive and encompassing intellectual environment with an accomplished faculty, daily interactions with other trainees and faculty, and frequent lectures or "grand rounds" by leading outside experts on varied, specialty topics.

I find it extremely cynical and hubristic that many psychologists and a number of psychopharmacology training programs for psychologists believe that advanced training in clinical psychopharmacology can be adequately accomplished in training programs where trainees are, at most, "part time" trainees who can maintain full-time practices or professional positions while completing much of their training in online and/or in brief "fly in" courses lasting relatively short periods of time. It is bemusing that the discipline of psychology appears to be adopting a model of advanced training that appears far less intense and much more opportunistic than colleagues in other health-related professions. I just don't get why many of our colleagues would find the cadre of currently existing programs endeavors that they would be proud to complete. The ideal is that a well trained psychologist with

expertise in clinical psychopharmacology would be in a unique position to integrate principles of behavioral science and pharmacology and to provide a true integration that would further society's ability to treat mental disorders. It is not at all clear that the current instantiation of training curricula can even begin to do this.

The adequacy of training is of paramount importance when one recognizes that the scope of best practices in psychiatry involves using drugs that all too frequently have serious psychiatric and nonpsychiatric, medical side effects. Some of these can be imminently life threatening (e.g., neuroleptic malignant syndrome, Stevens Johnson syndrome, acute pancreatitis) and others can involve major chronic health problems (e.g., type 2 diabetes). Earlier this year, prescription privilege advocates attempted to revise the New Mexico licensing law to expand the current formulary beyond the statutory limitations imposed by the original legislation which restricted permissible prescribing to those psychoactive drugs that have FDA indications for specific psychiatric conditions and populations. Specifically, they sought to include "off label" prescribing when such prescribing is accepted practice.

Clearly, the desire to expand the formulary is understandable and "off label" prescribing is common practice in psychiatry. This is especially true in the area of child mental health where a large amount of prescribing is "off label" because either many drug companies choose not to pursue pediatric indications from the FDA for drugs after gaining approval for adults and/or because the drug is approved for another pediatric condition. Additionally, a number of medications that do not have any FDA-approved indications for mental health conditions are often used "off label" to treat mental disorders. For example, at least two different types of medications used in the treatment of cardiovascular diseases are used as second-line or third-line treatments for ADHD and anxiety disorders. While these drugs are commonly used in internal medicine and most physicians would be expected to have considerable practical experience with these during their medical training, it is unclear how much practical experience most prescribing psychologists will have with these "off label" treatment options during their limited training (which only requires a minimum of 100 patients according to the APA Model Curriculum).

It is also unclear to what extent psychologists will see a need to expand the formulary to include nonpsychoactive drugs to treat common but serious side effects of FDA-indicated treatments for mental disorders. That is, the concept of a core formulary for mental health disorders is inherently a very fuzzy one when we expand beyond only those treatments with specific FDA indications for psychiatric disorders. It is unclear to what extent the profession and the public at large appreciates this inherent dilemma and its implications for an appropriate training model to prepare psychologists for current and future practice.

I also believe that there has been an important change in both professional and lay persons' views concerning the safety of commonly used therapeutics and, especially, psychiatric medications in the nearly 10 years since the Model Curriculum was passed by APA Council. Although I suspect others might disagree, at the time of passage of the Model Curriculum, the relatively recent introductions of a new generation of antidepressant medications (i.e., the SSRIs) and of antipsychotic medications (i.e., the "atypicals") led to a perception that we finally had developed powerful new weapons against serious and common mental disorders that were free of the many troublesome and sometimes dangerous side effects that had characterized much of the earlier formulary. The recent addition of new "black box" warnings to both SSRIs and the atypical antipsychotics reflects increasing awareness by the FDA and the public that seemingly safe medications carry risks that were not evident or foreseen during drug development or the clinical trials that led to their initial approval. The point here is not that psychiatric medications are too risky for appropriately trained psychologists to administer, but that models of appropriate training conceived ten years ago may need to be reexamined in light of recent concerns about drug safety concerning both psychiatric side effects (e.g., suicidality) and nonpsychiatric side effects (e.g., diabetes). (The issue of drug efficacy and comparative efficacy with earlier existing drugs and with various psychological treatments are issues beyond the scope of this opinion piece.)

Last spring, the National Register (NR) and the Association of State and Provincial Psychology Boards (ASPPB) jointly drafted criteria for "designating" training programs in clinical psychopharmacology. The idea of having a certifying body to uphold training standards for existing and emerging training programs is to be applauded. However, for whatever reasons, the resulting ASPPB/NR criteria fall short of the APA Model Curriculum. These criteria were subsequently endorsed by APA's Board of Educational Affairs (BEA). Because these criteria appear to be more lax than those outlined in the Model Curriculum, I have written to the BEA to ask them to rescind their endorsement of the NR/ASPPB criteria and it is my understanding that the BEA will consider this request at their Fall meeting. A copy of my letter to BEA follows.

I would hope that all psychologists, especially those within APA, will take an active interest in the issue of advanced training in clinical psychopharmacology. Unlike the official APA policy on prescription privileges (which is, in my opinion, a done deal), the issue of quality of training is one of great moment and has critical implications for our profession, the quality of mental health care in this country, and for the public at large.

It is also about time for APA to revisit their Model Curriculum and I would hope that members of SSCP will be active in providing constructive input so that any revisions will promote a new model curriculum that all psychologists would be proud of.

MEMORANDUM

To: Cindy Carlson, Chair, BEA
Bob Walsh, Special Assistant to the Executive Director, APA Education Directorate

Cc: Norman Anderson, Chief Executive Officer, APA
Cynthia Belar, Executive Director for Education, APA
Jack Blanchard, President, Society for a Science of Clinical Psychology
Gerald C. Davison, President-elect, Society of Clinical Psychology
Nathalie Gilfoyle, General Counsel, APA

From: Kenneth J. Sher, University of Missouri-Columbia

Re: BEA's May 5, 2005 Letter of Support to Judy Hall supporting the ASPPB/NR Criteria for Designating Programs for Training in Clinical Psychopharmacology

I am writing to BEA to ask them to reconsider their "full support" of the ASPPB/NR document outlining criteria for designating programs for training in clinical psychopharmacology. At the outset I want to emphasize that I recognize and support APA's policy concerning the granting of prescriptive authority to appropriately trained psychologists in jurisdictions where such practice is authorized by state law. However, I am very concerned about the quality of such training and believe that the ASPPB/NR criteria are inconsistent with APA policy (as detailed in the 1996 Model Curriculum) and therefore should not be endorsed or supported by BEA. Please consider the following statements (in italics) from the May 5, 2005 letter of support to Judy Hall from Bob Walsh.

"In its statement of support BEA wished to make clear that the majority of BEA members feel strongly that the most appropriate setting for conducting training and achieving proficiency in psychopharmacology is within an academic setting, so that there are assurances that appropriate sequence of training and supervision of the required practicum, an integral part of such training, can be achieved."

It is not clear to me why, if "the majority of BEA members feel strongly that the most appropriate setting for conducting training and achieving proficiency in psychopharmacology is within an academic setting," they proceeded to express "full support" for the ASPPB/NR document which clearly leaves the door open for alternative training settings. The NR/ASPPB document contradicts official APA policy that states "The provider of this training program *must* [emphasis added] be a regionally-accredited institution of higher learning or another appropriately accredited provider of instruction and training.¹" Additionally, the official model curriculum, which as a Council action represents official APA policy, makes no mention of "affiliation" with an accredited university as do the ASPPB/NR criteria. Affiliation is a very loose concept that has no specific meaning in the context it is used. That is, the ASPPB/NR document appears to deviate from official APA policy in two critical ways, specifically, allowing non-accredited organizations to provide training and by allowing university-affiliated organizations to provide training.

"BEA also feels strongly that while continuing education coursework may be an appropriate vehicle for receiving training, reviewing knowledge, and keeping up-to-date on advances in psychopharmacology it is not an appropriate mechanism for providing the full sequence [emphasis added] of training, include the practicum, required to achieve proficiency in psychopharmacology."

The wording of this statement is very problematic. Specifically, it is not clear why *any* training in a designated curriculum should be via the continuing education route. (It is my understanding that, just last year, CEC recommended to BEA that the CE route should not be used for training in clinical pharmacology that leads to gaining prescriptive authority.) Continuing education typically does not require any formal admissions process (e.g., concerning documented prerequisites) nor rigorous evaluation of desired learning outcomes nor, in many if not most cases, transferable academic credit. Indeed, the 1996 Model Curriculum explicitly states "Didactic courses will be administered for *academic credit* [emphasis added] with careful attention to trainee evaluation" indicating that if a vendor is not accredited to provide "academic credit" it is not a legitimate vendor of educational training under the Model Curriculum. Moreover, by leaving the door open to *some* continuing education, there is a very slippery slope that could lead to a wide variety of potential problematic scenarios with respect to the nature and amount of training via a CE mechanism that might be deemed acceptable.

It is also appears that the “prerequisite” requirement of the 1996 document is considerably watered down in the ASPPB/NR document (see 7.C.i). Specifically, I would argue that there is no longer a prerequisite if it can be met “while enrolled,” a possibility that is expressly acknowledged in the ASPPB/NR document. It is not clear why BEA deemed this to be, yet, another acceptable deviation from the official APA policy document.

As a long-time member of APA I am pleased to see that BEA, whom I hold in high regard, is seriously concerned with the development of training in clinical psychopharmacology and am grateful for their involvement. For this reason I am greatly troubled by BEA’s “full support” of the ASPPB/NR criteria. BEA should encourage the profession to set the bar high for training in clinical psychopharmacology so that all psychologists will be proud of the training that our colleagues seeking prescription privileges receive. I understand that arriving at a consensus on things such as this can be a tortuous, political process. However, there is a relevant APA policy document (the 1996 Model Curriculum) to guide such decisions. It is also my understanding that it is a violation of the APA by-laws for any sub-component of APA to take a stand that contravenes APA policy. Although the ASPPB/NR criteria themselves may not violate APA policy (because neither the NR nor the ASPPB are components of APA), the BEA endorsement of “strong support” clearly does because the ASPPB/NR criteria fall short of the Model Curriculum in ways detailed above. For this reason, I request that the BEA reconsider its endorsement of the ASPPB/NR criteria in its current form and vote to rescind their letter indicating strong support. If the BEA believes that it is the 1996 Model Curriculum itself is flawed, perhaps the most sensible way to proceed is to convene a new task force to revise the Model Curriculum and have a new Model Curriculum passed by Council. However, the ASPPB/NR criteria appear to clearly contravene official APA policy that is currently in force and described in the 1996 Model Curriculum.

I have heard that some members of the BEA believed that the original intent of the “other accredited provider” by those drafting the model curriculum was to include APA-approved sponsors of CE. This argument does not hold for two interrelated reasons. (1) The issue is not original intent of the framers of the draft document but how the term was interpreted by Council because Council is the official policy-making arm of APA. Moreover, I have been informed by someone intimately involved in the drafting of the Model Curriculum that, “I believe what our group had in mind when we talked about accredited provider of instruction and training is those groups that regionally accredited universities and colleges as well as those that accredit hospitals for delivery of training.” Thus, the memory of those involved in the original drafting of the Model Curriculum appears to vary and that is why it is essential that the written policy be followed. (2) APA is, and has been for many years, very explicit about the use of terms like accredited, approved, designated, proficiency, and the like. Indeed, in the very same document, there is a clear distinction between APA-approved CE vendors and accredited university programs. Specifically, in the discussion of prerequisite training, the document states that such training “involves evidence of (1) successful completion of a planned sequence of courses at a regionally accredited institution of higher learning, or (2) evidence of successful completion of a planned sequence of continuing education courses offered by an accredited institution of higher learning or *an approved provider of continuing education [emphasis added]* ...” That is, it is simply not credible that “accredited” would be used to refer to APA-approved CE providers in one part of the document but that APA-approved CE providers would be distinguished from “accredited” programs in another part of the same document.

2004 SSCP Directory of Clinical Psychology Internships

Edited by William P. Horan & Jack J. Blanchard

The *Directory* was created by SSCP as a resource for graduate students, faculty members, and internship sites on research opportunities and opportunities to receive training in empirically supported treatments at predoctoral clinical psychology internships. The *Directory* is one aspect of SSCP’s efforts to promote the integration of science and practice in clinical psychology.

[Available Free On-Line at the SSCP Website!](http://www.sscpweb.org)

www.sscpweb.org



Don Fowles, Ph.D.
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2004 SSCP President

The controversy over prescription privileges for clinical psychologists has brought SSCP into conflict with APA. Some years ago a survey of SSCP members showed that our membership strongly opposed prescription privileges, and the results of this survey were posted on our web site. Although the statements endorsed by the membership were highly critical of prescription privileges, they were posted as the results of a survey and not as an official SSCP position. There never was a vote of the SSCP Board to endorse those statements, and nothing in the posting suggested that it was an official position of SSCP.

In 2003 the SSCP Board was advised that (a) we were in violation of an APA policy that states that no division or section can publicly disagree with APA policy, and (b) that APA would take legal action that might result in our being thrown out of APA if we did not remove the offending posting from our web site. We understood it would not be sufficient to add a preamble to the posting indicating that it was not "official" SSCP policy. After a debate with strongly differing views, a majority of the Board voted to accept APA's position and remove the document from our web site (available to the public) and move it to one accessible only by APA members.

In December 2004 as President with full Board approval I wrote a letter to Norman Anderson, APA's Chief Executive Officer, urging APA to reconsider and reverse the earlier decision forbidding us to post anything critical of APA on our public web site. The letter contained several arguments in support of this request:

- The APA attempt to suppress dissent on a nationally important policy issue violates constitutionally protected free speech.
- Suppression of dissent violates academic values and is more characteristic of a guild organization than one representing academics. As a result, APA appears not to represent all of psychology, especially not university-based psychology.
- In the context of accreditation, at least in the past, APA's control over accreditation was based on its claim to represent all of psychology. Suppression of dissent on a matter central to professional training and thus to accreditation might undermine APA's legitimacy as the organization controlling

accreditation.

- The essence of the criticisms of prescription privileges assumes that APA's implementation of its policy requires so little education and training in basic and applied science and practicum relevant to prescription privileges as to risk incompetence on the part of psychologists. The critics are not criticizing prescription privileges per se, but rather prescription privileges based on such modest training that it can be done "on the cheap" and thus be made available to large numbers of clinical psychologists. By attempting to suppress this criticism rather than openly rebut it, APA gives the impression of having something to hide on a matter of public safety.
- APA should consider whether they would be proud to defend this policy of suppressing dissent to academic psychologists, as well as to such outsiders as Congress, the news media, accrediting agencies, and the ACLU.
- APA also should consider that the members of CUDCP, SSCP, AABT, and the Academy of Psychological Clinical Science have strongly opposed prescription privileges. With such broad public opposition, it is pointless to suppress dissent by SSCP.

Norman Anderson took the letter to the APA Board of Directors, who have authority over such matters. In a response to my letter, he advised me that the Board concluded it could not reverse the earlier decision. He said that conclusion was mandated by Articles VI. 5. and VI. 7. of the APA Bylaws, which state that Divisions and Sections "must comply with APA Bylaws, Association rules and current policy." He further explained that legal counsels had assured APA that such restrictions were not a violation of free speech rights. The APA Bylaws do not prohibit members from stating their disagreements with APA policy in a private capacity, only that they cannot do so on behalf of any part of APA. Additionally, he emphasized that SSCP is free to disagree with APA policy and to advocate for alternative positions *within* APA, and he encouraged SSCP to do just that. However, SSCP is not free to express disagreement with APA policy outside of APA.

Anderson's letter did not discuss the point that what was posted was not SSCP policy, but only the results of a survey of its members. Neither did his letter address the other concerns in my letter—e.g., APA's position represents guild values over academic values, the suppression of dissent undermines APA's claim to represent all of psychology and puts it in the position of hiding criticisms on a matter of public safety.

My own reaction to Anderson's letter is that it confirms important points made in the initial letter to him: that at the level of governance APA is dominated by guild/practitioner interests to such a degree that (a) they do not represent scientific and academic values and (b) are unwilling to allow public debate about the quality of training regarding prescription privileges and/or the attitudes of training programs about prescription privileges. In expressing this view, it is important that I recognize that APA sponsors important scientific

ventures—especially publication of journals—and that there are many individuals and some structural components of APA that strongly support science. Nevertheless, in my view ultimately APA has become a guild organization representing practitioner interests.

This exchange underscores the debate regarding whether SSCP should remain within APA or establish itself as an organization independent of APA. Advocates of staying within APA point to the importance of providing a voice advocating science within APA, to SSCP's strong representation in Division 12, and to the various activities sponsored by SSCP at the annual APA meetings. Advocates of making SSCP independent of APA point to the dominance of guild/practitioner interests in APA that makes advocacy of scientific/academic values futile. It is a difficult issue about which I feel considerable conflict.

Awards and Recognition: 2005 SSCP Student Poster Award Winners

[American Psychological Association, Washington, DC](#)

Seth J. Gillihan & Martha J. Farah

University of Pennsylvania

Recovery From Sad Mood: Effects of Depression History
and Mood Regulation Strategy

**Leslie Karwoski, Jennifer A. Prohaska, Kenneth A. Lehman,
Brian A. Stites, Dana Steidtmann, & Stephen S. Ilardi**

University of Kansas

Therapeutic Lifestyle Change (TLC) for Depression: Initial Results With
a Severely Depressed Outpatient Population

[American Psychological Society, Los Angeles, CA](#)

Leslie Park, A., Sher, K.J., Krull, J.L.

University of Missouri

Selection and Socialization Effects of Residence Arrangement
and Greek Involvement on Drinking During the Transition to College

Update from the Secretary/Treasurer

Denise Sloan, Ph.D.
Temple University

Report on Budget and Membership

We currently hold \$11,540 in the SSCP budget. In 2005 we had 259 paid members, 82 of whom are students. This number is down from previous years. In an attempt to increase the number of our members who renew their membership for the upcoming year we will send out renewal notices to people who were members within the past three years. We will also send out at least one reminder notice this year. In general, members seem to prefer the on-line renewal option with more than half of our members renewing on-line during the past year. We will certainly continue to offer members the option of on-line renewals.

Announcement of 2006 SSCP Dissertation Grants

Applications are now being accepted for SSCP Dissertation Grant Awards. These awards are intended to both recognize and support students who have already received approval for their dissertation project. Accordingly, in addition to the evaluation of the proposal as a whole, we will also consider what additional sources of funding have been received in the context of the overall estimated cost of the project.

Awards will be in the amount of \$500. It is anticipated that up to 5 grants will be funded. Eligibility requirements and application instructions are listed below.

Applications must be received by **November 1, 2005**. Notification of awards will be made no later than January, 2006.

Eligibility requirements:

- 1) Student member of SSCP. (Application for membership may be made at time of award submission. Annual student membership fee in SSCP is \$10. Make check payable to SSCP. Please include a completed application form with your proposal. The form can be downloaded from the SSCP website: www.sscpweb.org)
- 2) Current enrollment in an APA-approved doctoral program in Clinical Psychology.
- 3) Dissertation proposal approved by applicant's department.

The application should include the following:

- 1) Cover letter indicating applicant's name, school affiliation, mailing address, phone number, e-mail address, title of the project, and a statement that dissertation proposal has been approved.
- 2) Research Plan.
 - a. Specific Aims. List broad objectives and what the specific research proposed in this application is intended to accomplish.
 - b. Background and Significance. Briefly sketch the background leading to the present application, critically evaluate existing knowledge, and specifically identify the gaps that the project is intended to fill.
 - c. Preliminary studies. Use this section to provide account of applicant's preliminary studies (if any) pertinent to the application and/or any other information that will help establish the experience and ability of the applicant to pursue the proposed project.
 - d. Research Design and Methods. Describe the research design and the procedures to be used to accomplish the specific aims of the project. Include how the data will be collected, analyzed, and interpreted.

THE RESEARCH PLAN MAY BE A MAXIMUM OF 5 SINGLE-SPACED PAGES (INCLUDING REFERENCES).

- 3) Abstract. (Maximum 250 words, the abstract page does NOT count towards the 5 page maximum above. Research plan = 5 pages. Abstract = 1 additional page.)
- 4) Outline of budget and listing of additional sources of funding. (How do you propose to spend the award? What funding have you already received? To which additional sources of funding have you applied?) MAXIMUM OF 1 PAGE.
- 5) A very brief letter from dissertation advisor confirming your good standing in the program and stating that the dissertation prospectus has been successfully presented. (*Please note that this is a change from previous years. A letter of recommendation is NOT requested. The letter should simply confirm your standing and status of your prospectus.*) Only one copy of this letter is requested.
- 6) Curriculum vitae.

SUBMIT COVER LETTER AND FOUR (4) COPIES OF ALL MATERIALS (except advisor's letter) TO:

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